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ABSTRACT

This paper presents an example of a patient treated in a school-based clinic. The counselor used traditional diagnostic perspectives to come up with a diagnosis that would be understood by the patient's Health Maintenance Organization. This diagnosis reflects traditional understanding of mental health and psychological treatment, which promotes the interpretation that mental health is a function of intrapsychic and behavioral factors. Using the medical model, the assumption has been that once the behavioral manifestations of a disorder are determined, then assumptions have to be made about the cause and treatments must be recommended on a normative understanding of the disorder. Increasingly, the mental health establishment has sought, through controlled experimentation, to determine what treatment protocols work best with which mental health disorders. The case described in this paper highlights the challenges to mental health care professionals' reliance on empirically validated treatment (EVT). To be empirically validated, a treatment needs specific guidelines. The factors that lead to EVT are the very factors that challenge the development of culturally relevant or specific EVTs. As the counselor in this case struggled with assessing and developing a treatment plan for her client, she realized that a traditional diagnosis and treatment plan were insufficient to the client's needs. This paper offers the following four suggestions in regard to EVTs: articulate a theory of culturally relevant treatment, value ecological validity, focus on nonspecific factors in EVT, and our own values. (Author/MKA)

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Validating Culturally Relevant Treatment Interventions: What are We Trying to Change?

or

Challenges to the development of Culturally Relevant or Specific Empirically Validated Treatment.

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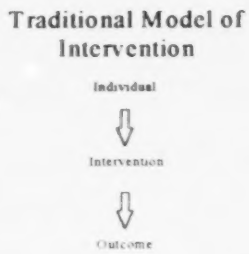
A recent consult with a colleague captured the challenge of establishing empirically validated treatments that are either culturally specific or sensitive. While working in a school-based clinic, a young (late 20's) mother was referred to my colleague to address concerns about her child's behavior. The mother came into the clinic with Aryan Nation paraphernalia and proceeded to share a complex history that included being sexually abused by her father with whom she shared intense ideologies concerning the superiority of Caucasians. In fact, the women, through her maternal heritage, had relatives who were ethnic minorities. She also lived in an ethnically diverse area. The mother was resistant to treatment and was unconvinced that her child needed counseling either. She did report having a difficult time managing her child and felt threatened by her neighbors. Using traditional diagnostic perspectives, my colleague was considering an adjustment disorder with anxiety and depression as the one most likely to be understood by the woman's HMO.

This diagnosis reflects our traditional understanding of mental health and psychological treatment.. This understanding promotes the interpretation that mental health is a function of intrapsychic and behavioral factors. Using the medical model, the assumption has been that once you determine the behavioral manifestations of a disorder, then you can make assumptions about the cause and recommend treatment based on a normative understanding of the disorder. Increasingly, the mental health establishment has sought, through controlled experimentation, to determine what treatment protocols work best with which mental health disorders. The mother described above highlights the challenges to our



reliance on empirically validated treatment.

To be empirically validated, a treatment needs specific qualities. The problem or behavioral disorders needs to be clearly defined, (e.g, depression or academic underachievement). The goals and processes of the treatment need to be explicit. What counts as change needs to be identified and measurable as are the techniques that are used to stimulate change. Another key ingredient of empirically validated treatment is that it is evaluated in direct comparison to alternate forms of treatment that are also systematically applied. At very least, an EVT is theory-driven, systematically applied to a specific population, and systematically evaluated using reliable and valid measures of change.

The factors that lead to becoming an EVT are the very factors that challenge the development of culturally-relevant or specific EVT's. What is our received or achieved theory concerning effective and culturally relevant treatment? What combination of cultural factors (e.g., gender, class, ethnicity, or sexual orientation), emotional disturbance (depression, PTSD, or conduct disorder), and context (rural, urban, in school, or psychiatric ward) is used to define the "specific population?" How do we define change from a cultural perspective? Do we have enough measurements that have been normed on difficult to define specific populations to make accurate assessments of a client's psychological status prior to and after treatment? I want to use the balance of my time to further articulate these challenges and propose some guidelines to the development of culturally relevant or specific EVT's.

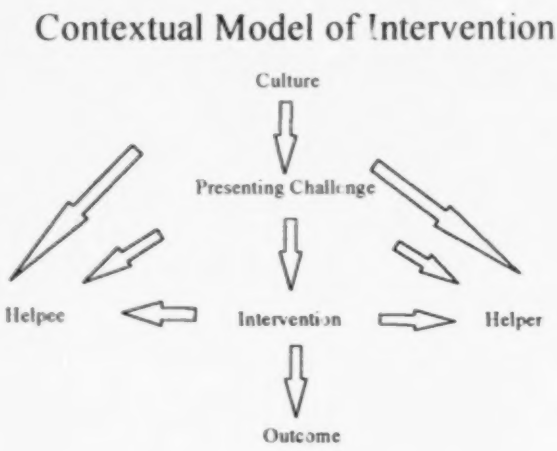
As my colleague struggled with assessing and developing a treatment plan for her client, she realized that a traditional diagnosis and treatment plan was insufficient to the client's needs. Let alone helping the client resolve her issues as a sexual abuse victim (neither her presenting problem nor a diagnostic category that leads to 3rd party payment) or working through the

parenting issues that brought her into counseling, my colleague also recognized the social aspects of the client's difficulties, e.g., deep-seated, generational hatred creates barriers to the individual's emotional development and for the individual's community. Knowing the difficulty of getting reimbursed for an adjustment disorder, that the client did not have the resources or motivation to engage in traditional office-based treatment, and holding the belief that this client needed to have her cultural perspective taking challenged, my colleague facilitated her enrollment in a parenting group with other low-income women who had a variety of cultural backgrounds. My colleague believed that such an intervention would have several benefits. The first is that it would allow the client to come into treatment with less resistance as the manifest focus would be on her child and the skills she needed to serve that child well. In the group, she would come into contact with ethnic minorities as individuals which *could* serve to expand her perspective on issues of racial hierarchy. Just as important, my colleague knew that one of the ongoing topics of conversation in the group concerned how a substantial percentage of the mothers' history as a sexual assault/abuse victims affected their parenting. My colleagues assumption is that conversation could trigger her client's reevaluation of her relationship with her father which my colleague saw as reinforcing the client's rigid approach to parenting - one source of the parent-child conflict.

Given the perspective that clinicians should limit their practice to EVT's in order to practice ethically, how can my colleague know she is doing the right thing? How can we, as scientists, assist her in managing the needs of such a client with confidence and ethics.

Articulate A Theory of Culturally Relevant Treatment: The first step in developing culturally relevant EVT's is the articulation of a theory. My colleague needs an articulate rational for why she chose to treat the combination of social (race hatred) and interpersonal (victimization) issues in her client rather than the adjustment disorder. We have come a long way

from a rigid focus on intrapsychic issues in counseling and from a unidimensional understanding in counseling. What we still need to train clinicians to do is have an articulate and systematically derived theory of how culture affects the counseling process. Clinicians often leave school and become involved with particular clients within a particular context. In order to develop a theory-driven practice, clinicians need to articulate precisely how they think cultural factors effect the client's development of a presenting challenge, a context's understanding of that presenting challenge, and what works in resolving such a challenge for particular clients. It is through the systematic maintenance and analysis of one's case notes that clinicians can derive their theory.

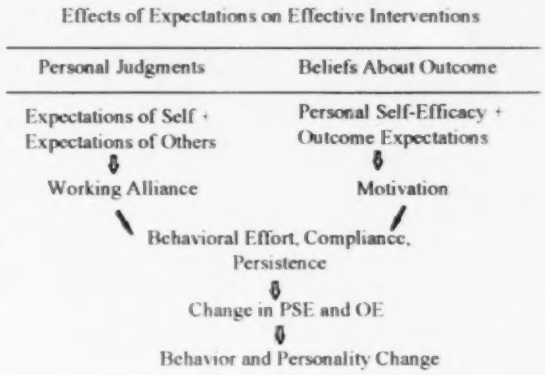


As a field, we need to have access to these grounded theories of culturally relevant practice. Ongoing efforts need to be made so that clinicians and students of the clinical process have access to these systematic case studies so that we can develop an aggregate understanding of effective practice. Based on that aggregate understanding, we can develop theories as to what works well with whom. We can then use those theories to develop standardized protocols as the basis of culturally relevant EVT'S.

Value Ecological Validity: Another step in the development of CR-EVT's is the willingness of journal editors to value ecological validity. This valuation needs to take two forms. The first is to publish studies that replicate and extend EVT's that have been normed on one

cultural population to other cultural groups. The other is to demand that researchers extend work to culturally diverse population as part of their original work. We know a lot about the role of cognitive behavioral treatment for depression and anxiety but much less about their validity with ethnically diverse groups.

Focus on Non-Specific Factors in EVT: We need more research in the clinical literature on those issues that have been addressed in the analogue research such as ethnic matching or cultural empathy. EVT's place substantial focus on the techniques of treatment. From a cultural perspective, it is also important to evaluate the relationship between competent techniques and other counseling variables such as relationship building. We need to know how members of different cultural groups experience a phenomena such as relationship building, how it is effected by context, and how it effects outcome.



Own our Values: I want to end with an acknowledgment that we need to aware of and own the values that we bring to this topic and to address them explicitly in both our clinical and scientific endeavors. Let me give you a concrete example. My colleague, Christopher Bass, is completing an investigation in which he compared a culturally specific intervention with African American academic underachievers to a traditional social skills intervention with the same population. On measures of academic self-efficacy, classroom behavior, academic achievement, and general school conduct, both interventions were equally effective with substantive changes pre and post treatment. One person might say that we do not need to do the culturally specific

treatment as the general treatment is good enough. Of course, there is the other voice which will argue for the value added nature of the cultural information the students' receive. It is here that we need to be honest about our political values and articulate them as we choose the treatments we value.